

MEDICAL EXAMINER'S REPORT

8. a. Height (In Shoes)	Weight (Clothed)	Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen at Umbilicus
ft. in.	lbs.	in.	in.	in.

b. Did you weigh? Yes No Did you measure? Yes No

9. Blood Pressure (Record ALL readings)

Systolic			
4th phase			
Diastolic			
5th phase			
	At Rest	After Exercise	3 Minutes Later

10. Pulse:
Rate _____
Irregularities _____

11. Heart: Is there any:

Enlargement Yes No Dyspnea Yes No
Murmur(s) Yes No Edema Yes No

(describe below - if more than one, describe separately)

Location	<input type="checkbox"/>	<input type="checkbox"/>	
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Indicate:
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>	
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	
Localized	<input type="checkbox"/>	<input type="checkbox"/>	Apex by X
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by
Mod (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>	
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>	
After exercise:			
Increased	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by
Absent	<input type="checkbox"/>	<input type="checkbox"/>	
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased	<input type="checkbox"/>	<input type="checkbox"/>	Please record your comments or impressions.

18. Urinalysis Albumin	Sugar	Blood
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Have you mailed the urine specimen? Yes No
Specimen must be mailed in Union Central Life mailer if any of the following factors apply:

1. Age 60 or over.
2. Amount of life insurance is \$100,000 or more.
3. Current Blood Pressure reading over 140/90.
4. Albumin, sugar or occult blood is present in the urine test completed.
5. History of or findings of overweight, elevated blood pressure, cardiovascular or genitourinary disease or diabetes mellitus.
6. Either parent, or a brother or sister has or had diabetes.

Details of "Yes" answers. (Identify item.)

12. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
a. Eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
(If vision or hearing markedly impaired, indicate degree and correction.)		
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
c. Nervous system (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
e. Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Genitourinary system?	<input type="checkbox"/>	<input type="checkbox"/>
g. Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
h. Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>

13. a. Are there any hemias? Yes No

14. Are you aware of additional medical history? Yes No
(A confidential report may be sent to the Medical Director)

15. Is appearance unhealthy or older than stated age? Yes No

16. Has the applicant used any form of tobacco within the past 24 months? Yes No
Indicate: Cigarettes Cigar Pipe Chew or "Smokeless"

17. How long and how well have you known the applicant?

Amount of Fee \$ _____

Examined at: applicant's residence on _____, year _____, at _____ a.m. _____ p.m.
 applicant's business
 examiner's office Signature of Examiner _____ M.D. or D.O. Paramedic
 Examiner's Name (Please Type or Print) _____

Examiner's Social Security Number _____ Examiner's Address _____
 or Taxpayer Identifying Number _____ Agent Agency Address _____

At request of _____, Agent _____

AUTHORIZATION

I authorize any physician, medical professional, hospital, clinic, other medical care institute, Medical Information Bureau, insurer, consumer reporting agency, or employer having information available as to other insurance coverage, medical care, advice, treatment, or supplies with respect to any physical or mental condition or any other information regarding me, to give the information to The Union Central Life Insurance Company, or its reinsurers.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information.

I understand that this information will be used by The Union Central Life Insurance Company to determine eligibility for insurance.

I agree this authorization is valid for two and one-half years from the date shown below.

I know that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

Date

Signed



HIV Antibody Testing Consent Form

The insurance company to which you have applied may request a body fluid sample from you for testing. One test will be to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV). HIV is the virus which causes AIDS. California law requires an insurance company to obtain your written consent in order to test for the presence of an antigen or antibody to HIV. The results of this test may determine your eligibility to acquire insurance. By signing this form you have consented to the HIV test and the reporting of the test results to the insurance company taking your application. Positive test results will not be disclosed except as authorized by you in writing. Negative and indeterminate (inconclusive) test results may be disclosed to reinsurers, contractually retained medical personnel and insurance affiliates or subsidiaries that are involved in necessary underwriting decisions regarding your application. The insurance company and any other party receiving the negative or indeterminate test results will maintain the results of your HIV antibody test as confidential.

If your test results indicate the presence of antibodies to HIV, or if your test results cannot be accurately determined, the insurance company will report a "nonspecific abnormality" to the Medical Information Bureau. The Medical Information Bureau contains the names and computerized medical records of insurance applicants nationally. The report will not identify you as having an abnormal HIV antibody test because many other abnormalities are reported to the Bureau under the same classification.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred within the previous 3 - 6 months.

If your antibody test is positive, it does not mean you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needles, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible.

A negative test result means no antibodies to the HIV virus were found. Because of various incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

The insurance company will notify your physician if your test results are positive or if your results cannot be accurately determined. You should request that your results be sent to your private physician so that he can interpret them for you.

In the event of a positive or indeterminate test result, I authorize disclosure to the following physician:

Name _____

Address _____

INFORMED CONSENT

I have read and understand this information, I voluntarily consent to the withdrawal and the testing of body fluids, and the disclosure of the test results as described above.

Name of Proposed Insured

Signature of Proposed Insured

Date Signed by Proposed Insured

State of Residence



Authorization to Obtain and Disclose Information

(This authorization complies with the HIPAA Privacy Rule.)

Full Name of Applicant/Insured _____

Policy Number (if applicable) _____

I authorize any health care providers, hospitals, insurers, the Medical Information Bureau, Inc., consumer reporting agency, government agency, financial institution, or employer; having data or facts about the proposed insured's or claimant's physical or mental condition, medical care, advice, treatment, the use of drugs, alcohol, or tobacco, HIV, AIDS and sexually transmitted diseases, prescription drug records, financial status, employment status or other relevant data or facts about the proposed insured or claimant; including wage and earnings, or data or facts with respect to other insurance coverage; to give all data or facts to The Union Central Life Insurance Company ("the Company"), its reinsurers, or any other agent or agency acting on the Company's behalf.

Data or facts obtained will be released only to: (1) reinsurers; (2) the MIB; (3) persons performing business duties as delegated or contracted for by the Company related to the proposed insured's application or claim or other insurance-related functions; (4) as permitted or required by law; (5) to government authorities when necessary to prevent or prosecute fraud or other illegal acts; (6) and to any person or entity having an authorization expressly permitting the disclosure. The personal data or facts used or disclosed under this authorization may be subject to redisclosure and no longer protected by federal privacy regulations.

The above data and facts will be used to: (1) underwrite an application for coverage; (2) obtain reinsurance; (3) resolve or contest any issues of incomplete, incorrect, or misrepresented information on the application identified above which may arise during the processing or review of the application, or any other application for insurance; (4) administer coverage and claims; and (5) complete a consumer report, investigative consumer report or telephone interview about the proposed insured or claimant.

I agree that this authorization is valid for two and one-half years from the date shown below (except MN, which is valid for two years and two months). I also agree that a copy is as valid as the original. I or my authorized representative am entitled to a copy. For purposes of collecting data or facts relating to a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revoking this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failing to sign, or revoking this authorization may impair the Company's ability to process my application or evaluate my claim and may be a basis for denying this application or a claim for benefits.

(If at time of application) I acknowledge receipt of Notice of Insurance Information Practices.

Signature of Proposed Insured or Claimant or Personal Representative

Date

Print or type name

Description of Personal Representative's Authority or Relationship to Proposed Insured or Claimant

The Union Central Life Insurance Company, P.O. Box 40888, Cincinnati, Ohio 45240

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